DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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FACT SHEET

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2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

Background

On April 5, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that revises the Medicare Advantage (MA or Part C), Medicare Prescription Drug Benefit (Part D), Medicare Cost Plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations to implement changes related to Star Ratings, marketing and communications, health equity, provider directories, coverage criteria, prior authorization, network adequacy, and other programmatic areas. This final rule also codifies regulations implementing section 118 of Division CC of the Consolidated Appropriations Act, 2021, and section 11404 of the Inflation Reduction Act, and includes provisions to codify existing sub-regulatory guidance in the Part C, Part D, and PACE programs.

In this final rule, CMS is not addressing comments received on the provisions of the proposed rule that we are not finalizing at this time. Rather, the agency will address them at a later time, such as in possible future rulemaking, as appropriate.

This fact sheet discusses the major provisions of the final rule. The final rule can be downloaded here: https://www.federalregister.gov/public-inspection/current.

Enhancements to Medicare Advantage and Medicare Part D

Ensuring Timely Access to Care: Utilization Management Requirements
CMS has received numerous inquiries regarding the use of prior authorization by Medicare Advantage plans and the effect on beneficiary access to care. In the rule, CMS finalizes impactful changes to address these concerns and to advance timely access to medically necessary care for enrollees.

The final rule clarifies clinical criteria guidelines to ensure people with MA receive access to the same medically necessary care they would receive in Traditional Medicare. This aligns with recent Office of Inspector General (OIG) recommendations. Specifically, CMS clarifies rules

related to acceptable coverage criteria for basic benefits by requiring that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare regulations. CMS is also finalizing that when coverage criteria are not fully established, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers. In the final rule, CMS more clearly defines when applicable Medicare coverage criteria are not fully established by explicitly stating the circumstances under which MA plans may apply internal coverage criteria when making medical necessity decisions. CMS believes that permitting the use of publicly accessible internal coverage criteria in limited circumstances is necessary to promote transparent, and evidence-based clinical decisions by MA plans that are consistent with Traditional Medicare.

The final rule also streamlines prior authorization requirements, including adding continuity of care requirements and reducing disruptions for beneficiaries. CMS' final rule requires that coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary. Second, this final rule requires coordinated care plans to provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan, during which the new MA plan may not require prior authorization for the active course of treatment. Third, to ensure prior authorization is being used appropriately, CMS is requiring all MA plans establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines. Finally, to address concerns that the proposed rule did not sufficiently define the expected duration of "course of treatment," the final rule requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

Together, these changes will help ensure enrollees have consistent access to medically-necessary care while also maintaining medical management tools that emphasize the important role MA plans play in coordinating medically-necessary care.

Protecting Beneficiaries: Marketing Requirements

The final rule also takes critical steps to protect people with Medicare from confusing and potentially misleading marketing while also ensuring they have accurate and necessary information to make coverage choices that best meet their needs. The proliferation of certain television advertisements generically promoting enrollment in MA plans has been a specific topic of concern. To address these concerns, CMS is prohibiting ads that do not mention a specific plan name as well as ads that use words and imagery that may confuse beneficiaries or use language or Medicare logos in a way that is misleading, confusing, or misrepresents the plan. In the rule, CMS also reinstates important protections that prevent predatory behavior and finalized changes that strengthen the role of plans in monitoring agent and broker activity. CMS is also finalizing requirements to further protect Medicare beneficiaries by ensuring they receive accurate information about Medicare coverage and are aware of how to access accurate information from other available sources.

CMS is finalizing 21 of the 22 provisions we proposed, with 17 of the 21 provisions being finalized as proposed. The four provisions CMS is finalizing but modifying include: permitting agents to make Business Reply Cards available at educational events; requiring an agent to tell prospective enrollees how many plans are available from the organization for whom the agent sells; extending the length of time agents are able to re-contact beneficiaries to discuss plan options to twelve months; and allowing an agent to meet with a beneficiary without waiting the full 48-hour cooling off period when the timeframe runs up against the end of an election period, or a beneficiary faces transportation or access challenges, or the beneficiary voluntarily walks into an agent's office. CMS will continue to explore including the provision that is not being finalized in this rule in possible future rulemaking.

Strengthening Quality: Star Ratings Program

CMS continues improvements to the Star Ratings program by finalizing new methodological enhancements to further drive quality improvement for all enrollees. In this rule, CMS finalizes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors. CMS also reduces the weight of patient experience/complaints and access measures to further align with other CMS quality programs and the current CMS Quality Strategy. In addition, CMS includes an additional rule for the removal of Star Ratings measures and removes the 60 percent rule that is part of the adjustment for extreme and uncontrollable circumstances. The changes will further drive quality improvement and health equity in MA and Part D.

Advancing Health Equity

CMS is committed to advancing health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.[1] CMS is clarifying current rules, expanding the example list of populations that MA organizations must provide services in a culturally competent manner. These include people: (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minorities; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.

Studies demonstrate low digital health literacy, especially among populations experiencing health disparities, continues to impede telehealth access and worsen care gaps particularly among older adults. CMS is finalizing requirements for MA organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to medically necessary covered telehealth benefits. In addition, CMS is enhancing current best practices by requiring MA organizations to include providers' cultural and linguistic capabilities in provider directories. This change will improve the quality and usability of provider directories, particularly for non-English speakers, limited English proficient individuals, and enrollees who use American Sign Language. Finally, CMS is requiring that MA organizations' quality improvement programs include efforts to reduce disparities.

[1] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

Improving Access to Behavioral Health
CMS recognizes the importance of building strong MA behavioral health networks that improve timely access to services. CMS is finalizing policies strengthening network adequacy requirements and reaffirming MA organizations' responsibilities to provide behavioral health services. Specifically, CMS will: (1) add Clinical Psychologists and Licensed Clinical Social Workers as specialty types for which we set network standards, and make these types eligible for the 10-percentage point telehealth credit; (2) amend general access to services standards to include explicitly behavioral health services; (3) codify standards for appointment wait times for primary care and behavioral health services; (4) clarify that emergency behavioral health services must not be subject to prior authorization; (5) require that MA organizations notify enrollees when the enrollee's behavioral health or primary care provider(s) are dropped midyear from networks; and (6) require MA organizations to establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole-person care.

Implementation of Certain Provisions of the Consolidated Appropriations Act, 2021 and the Inflation Reduction Act of 2022

The final rule also makes changes to the Part C and D programs stemming from the Inflation Reduction Act (IRA) of 2022 and the Consolidated Appropriations Act (CAA), 2021.

Making Permanent: Limited Income Newly Eligible Transition (LI NET) Program
LI NET currently operates as a demonstration program that provides immediate and retroactive Part D coverage for eligible low-income beneficiaries who do not yet have prescription drug coverage. In this final rule, CMS is making the LI NET program a permanent part of Medicare Part D, as required by section 118 of the CAA.

Enhancing Financial Stability: Expanding Low-Income Subsidies Under Part D
CMS is finalizing regulations to expand eligibility for the full low-income subsidy (LIS) benefit (also known as "Extra Help") to individuals with incomes up to 150% of the federal poverty level who meet eligibility criteria. Beginning January 1, 2024, this change will provide the full low-income subsidy to those who currently qualify for the partial subsidy. This implements section 11404 of the IRA and will improve access to affordable prescription drug coverage for approximately 300,000 low-income individuals with Medicare.

Implementation of Certain Provisions of the Bipartisan Budget Act of 2018 and the Consolidated Appropriations Act, 2021
Finally, the rule finalizes several changes stemming from federal laws related to the Part C and D programs—including the Inflation Reduction Act (IRA) of 2022, the Consolidated Appropriations Act (CAA) of 2021, and the Bipartisan Budget Act (BBA) of 2018.

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